PLEASE COMPLETE AND RETURN THIS FORM TO YOUR EMPLOYER.

Flexible Spending Accounts Enrollment and Status Change Form

Please print clearly.

Employer/Company Name: _____ Division: _____

Last Name: _____ First Name: _____ SSN#: _____

Address: _____

City: _____ State: _____ Zip: _____

FOR H.R. USE ONLY:	Effective Date: _____	Status Change Date: _____
	Termination Date: _____	No. of Pay Periods: _____

Premium Only Plan—I understand that any premiums I am obligated to pay for health care coverage for myself and my eligible dependents will be deducted from my pay on a pretax basis unless I otherwise direct.

ANNUAL ENROLLMENT ELECTION—Indicate plan(s) selection below:

HEALTH CARE FSA (please check one) refer to your employer's enrollment materials for your Plan's Annual Maximum	**DEPENDENT CARE FSA (please check one)** $5,000 Annual Maximum (or $2,500 if married filing separately)
❑ I wish to redirect $_____ for the upcoming plan year. ($_____ per pay period) to my Health Care FSA.	❑ I wish to redirect $_____ for the upcoming plan year. ($_____ per pay period) to my Dependent Care FSA. I have considered the IRS tax credit available to me. I understand that if I am married and filing a separate tax return, a lower maximum applies.
❑ I **do not** wish to redirect any money for eligible health care expenses.	❑ I **do not** wish to redirect any money for eligible dependent care expenses.

STATUS CHANGE—Complete the following and indicate the reason for the Change in Status:

❑ Change in legal marital status—including marriage, divorce, spouse's death, legal separation and annulment.	❑ Change in work schedule— reduction or increase in hours by employee, spouse or dependent
❑ Change in the number of tax dependents—including birth, adoption, placement for adoption or death.	❑ Change in residence or worksite of employee, spouse or dependent.
❑ Termination or commencement of employment by employee, spouse or dependent.	❑ Dependent satisfies (or ceases to satisfy) dependent eligibility requirements—attainment of age, student, status, etc.
❑ Change in dependent care provider or provider's cost.	❑ Other. Please explain _____

HEALTH CARE FSA		**DEPENDENT CARE FSA**	
Old Annual Election	**New** Annual Election	Old Annual Election	**New** Annual Election
$_____	$_____	$_____	$_____
Old Per Pay Amount	**New** Per Pay Amount	Old Per Pay Amount	**New** Per Pay Amount
$_____	$_____	$_____	$_____

Authorization—Read Carefully

I understand that the choices I have indicated above must remain in effect for the entire plan year unless I have an eligible change in family status. I authorize the above amounts to be deducted from my pay on a pretax basis. I understand that any unused balances in either the Health or Dependent Care FSAs at the end of the Plan Year shall be forfeited. I understand that the expenses that I claim for reimbursement must be incurred during the Plan Year while I am an eligible participant under my employer's Plan and that these expenses have not been reimbursed through any other plan or through any other method or means, nor will I seek reimbursement elsewhere. I understand that I am responsible for the sufficiency, accuracy and veracity of all information relating to my claims, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the plan which relate to such expense. I understand that no tax deduction is permitted for amounts for which reimbursement is made. I agree to comply by the terms of this Plan.

_____ _____

Signature of Employee **Date**

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